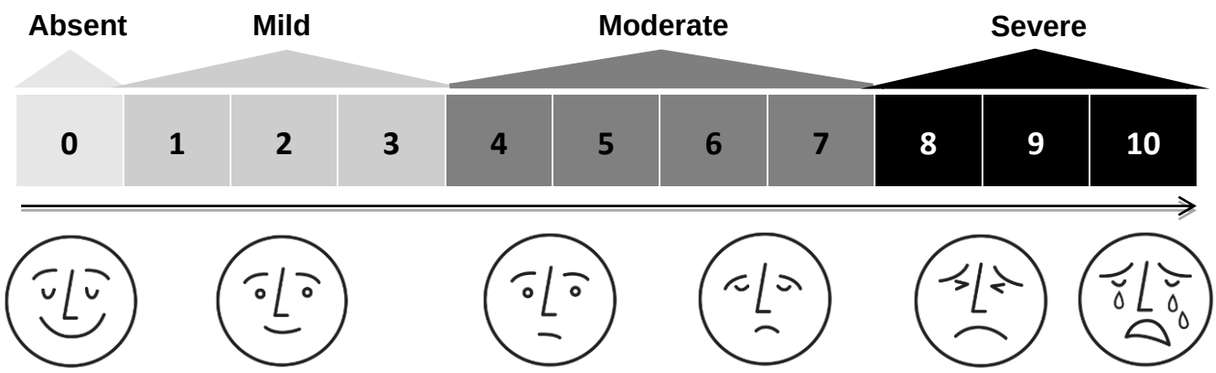
PCOC
palliative care
outcomes collaboration

(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Symptom Assessment Scale

Please use this form to tell us about the symptoms that bother, worry or distress you. This information will help us to meet your needs.



1. Write the day or date in the first row.
2. Use the scale above to choose a number between 0 and 10 that shows how bothered, worried or distressed you are.
3. You can add other symptoms in the blank space at the bottom of the list.

Day or date									
Difficulty sleeping									
Appetite problems									
Nausea									
Bowel problems									
Breathing problems									
Fatigue									
Pain									